Human Rights

HARMFUL TRADITIONAL PRACTICES AFFECTING THE HEALTH OF WOMEN AND CHILDREN

Fact Sheet No. 23

World Campaign for Human Rights

States Parties shall take all appropriate measures . . . to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women.

CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN*

(art. 5 (*a*))

* Adopted by General Assembly resolution 34/180 of 18 December 1979.

Introduction

The Charter of the United Nations includes among its basic principles the achievement of international cooperation in promoting and encouraging respect for human rights and fundamental freedoms for all without distinction as to race, sex, language or religion (Art. 1, para. 3).

In 1948, three years after the adoption of the Charter, the General Assembly adopted the Universal Declaration of Human Rights,[1] which has served as guiding principles on human rights and fundamental freedoms in the constitutions and laws of many of the Member States of the United Nations. The Universal Declaration prohibits all forms of discrimination based on sex and ensures the right to life, liberty and security of person; it recognizes equality before the law and equal protection against any discrimination in violation of the Declaration.

Many international legal instruments on human rights further reinforce individual rights, and also protect—and prohibit discrimination against—specific groups, in particular women. The Convention on the Elimination of All Forms of Discrimination against Women, for example, had been ratified by 136 States as of January 1995. The Convention obliges States parties, in general, to "pursue by all appropriate means and without delay a policy of eliminating discrimination against women" (art. 2). It reaffirms the equality of human rights for women and men in society and in the family; it obliges States parties to take action against the social causes of women's inequality; and it calls for the elimination of laws, stereotypes, practices and prejudices that impair women's well-being.

Traditional cultural practices reflect values and beliefs held by members of a community for periods often spanning generations. Every social grouping in the world has specific traditional cultural practices and beliefs, some of which are beneficial to all members, while others are harmful to a specific group, such as women. These harmful traditional practices include female genital mutilation (FGM);

[1] For the texts of the international human rights instruments cited in this Fact Sheet, see *Human Rights: A Compilation of International Instruments*, vol. I (2 parts), *Universal Instruments* (United Nations publication, Sales No. E.94.XIV.1).

forced feeding of women; early marriage; the various taboos or practices which prevent women from controlling their own fertility; nutritional taboos and traditional birth practices; son preference and its implications for the status of the girl child; female infanticide; early pregnancy; and dowry price. Despite their harmful nature and their violation of international human rights laws, such practices persist because they are not questioned and take on an aura of morality in the eyes of those practising them.

The international community has become aware of the need to achieve equality between the sexes and of the fact that an equitable society cannot be attained if fundamental human rights of half of human society, i.e. women, continue to be denied and violated. However, the bleak reality is that the harmful traditional practices focused on in this Fact Sheet have been performed for male benefit. Female sexual control by men, and the economic and political subordination of women, perpetuate the inferior status of women and inhibit structural and attitudinal changes necessary to eliminate gender inequality.

As early as the 1950s, United Nations specialized agencies and human rights bodies began considering the question of harmful traditional practices affecting the health of women, in particular female genital mutilation. But these issues have not received consistent broader consideration, and action to bring about any substantial change has been slow or superficial.

A number of reasons are given for the persistence of traditional practices detrimental to the health and status of women, including the fact that, in the past, neither the Governments concerned nor the international community challenged the sinister implications of such practices, which violate the rights to health, life, dignity and personal integrity. The international community remained wary about treating these issues as a deserving subject for international and national scrutiny and action. Harmful practices such as female genital mutilation were considered sensitive cultural issues falling within the spheres of women and the family. For a long time, Governments and the international community had not expressed sympathy and understanding for women who, due to ignorance or unawareness of their rights, endured pain, suffering and even death inflicted on themselves and their female children.

Despite the apparent slowness of action to challenge and eliminate harmful traditional practices, the activities of human rights bodies in this field have, in recent years, resulted in noticeable progress. Traditional practices have become a recognized issue concerning the status and human rights of women and female children. The slogan

"Women's Rights are Human Rights", adopted at the World Conference on Human Rights in Vienna in 1993, as well as the Declaration on the Elimination of Violence against Women, adopted by the General Assembly the same year, captured the reality of the status accorded to women. These issues have been further emphasized in the reports of the Special Rapporteur on harmful traditional practices, Mrs. Halima Embarek Warzazi, appointed in 1988, and in the draft Platform for Action for the Fourth World Conference on Women, to be held in September 1995.

The Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, appointed by the Commission on Human Rights in 1994, has also examined all forms of traditional practices referred to in this Fact Sheet, as well as other practices, including virginity tests, foot binding, female infanticide and dowry deaths, all of which violate female dignity. In her preliminary report, the Special Rapporteur pointed out that

> blind adherence to these practices and State inaction with regard to these customs and traditions have made possible large-scale violence against women. States are enacting new laws and regulations with regard to the development of a modern economy and modern technology and to developing practices which suit a modern democracy, yet it seems that in the area of women's rights change is slow to be accepted. (E/CN.4/1995/42, para. 67.)

The harmful traditional practices identified in this Fact Sheet are categorized as separate issues; however, they are all consequences of the value placed on women and the girl child by society. They persist in an environment where women and the girl child have unequal access to education, wealth, health and employment.

In part I, the Fact Sheet identifies and analyses the background to harmful traditional practices, their causes, and their consequences for the health of women and the girl child. Part II reviews the action taken by United Nations organs and agencies, Governments and non-governmental organizations (NGOs). The Conclusions highlight the drawbacks in the implementation of the practical steps identified by the United Nations, NGOs and women's organizations.

I. An appraisal of harmful traditional practices and their effects on women and the girl child

A. Female genital mutilation[2]

Female genital mutilation (FGM), or female circumcision as it is sometimes erroneously referred to, involves surgical removal of parts or all of the most sensitive female genital organs. It is an age-old practice which is perpetuated in many communities around the world simply because it is customary. FGM forms an important part of the rites of passage ceremony for some communities, marking the coming of age of the female child. It is believed that, by mutilating the female's genital organs, her sexuality will be controlled; but above all it is to ensure a woman's virginity before marriage and chastity thereafter. In fact, FGM imposes on women and the girl child a catalogue of health complications and untold psychological problems. The practice of FGM violates, among other international human rights laws, the right of the child to the "enjoyment of the highest attainable standard of health", as laid down in article 24 (paras. 1 and 3) of the Convention on the Rights of the Child.

The origin of FGM has not yet been established, but records show that the practice predates Christianity and Islam in practising communities of today. In ancient Rome, metal rings were passed through the labia minora of slaves to prevent procreation; in medieval England, metal chastity belts were worn by women to prevent promiscuity during their husbands' absence; evidence from mummified bodies reveals that, in ancient Egypt, both excision and infibulation were performed, hence Pharaonic circumcision; in tsarist Russia, as well as nineteenth-century England, France and America, records indicate the practice of clitoridectomy. In England and America, FGM was performed on women as a "cure" for numerous psychological ailments.

[2] See, generally, Fran P. Hosken, *The Hosken Report: Genital and Sexual Mutilation of Females*, 4th rev. ed. (Lexington (Mass.), Women's International Network News, 1994).

The age at which mutilation is carried out varies from area to area. FGM is performed on infants as young as a few days old, on children from 7 to 10 years old, and on adolescents. Adult women also undergo the operation at the time of marriage. Since FGM is performed on infants as well as adults, it can no longer be seen as marking the rites of passage into adulthood, or as ensuring virginity.

Among the types of surgical operation on the female genital organs listed below, there are many variations, performed throughout Africa, Asia, the Middle East, the Arabian Peninsula, Australia and Latin America.

Types of surgical forms

(*a*) Circumcision or Sunna (''traditional'') circumcision: This involves the removal of the prepuce and the tip of the clitoris. This is the only operation which, medically, can be likened to male circumcision.

(*b*) Excision or clitoridectomy: This involves the removal of the clitoris, and often also the labia minora. It is the most common operation and is practised throughout Africa, Asia, the Middle East and the Arabian Peninsula.

(*c*) Infibulation or Pharaonic circumcision: This is the most severe operation, involving excision plus the removal of the labia majora and the sealing of the two sides, through stitching or natural fusion of scar tissue. What is left is a very smooth surface, and a small opening to permit urination and the passing of menstrual blood. This artificial opening is sometimes no larger than the head of a match.

Another form of mutilation which has been reported is introcision, practised specifically by the Pitta-Patta aborigines of Australia. When a girl reaches puberty, the whole tribe—both sexes—assembles. The operator, an elderly man, enlarges the vaginal orifice by tearing it downward with three fingers bound with opossum string. In other districts, the perineum is split with a stone knife. This is usually followed by compulsory sexual intercourse with a number of young men.

It is reported that introcision has been practised in eastern Mexico and in Brazil. In Peru, in particular among the Conibos, a division of the Pano Indians in the north-east, an operation is performed in which, as soon as a girl reaches maturity, she is intoxicated and subjected to mutilation in front of her community. The operation is performed by an elderly woman, using a bamboo knife. She cuts around the hymen from the vaginal entrance and severs the hymen from the labia, at the same time exposing the clitoris. Medicinal herbs are applied, followed by the

insertion into the vagina of a slightly moistened penis-shaped object made of clay.

Like all other harmful traditional practices, FGM is performed by women, with a few exceptions (in Egypt, men are known to perform the operation). In most rural settings throughout Africa, the operation is accompanied with celebrations and often takes place away from the community at a special hidden place. The operation is carried out by women (excisors) who have acquired their "skills" from their mothers or other female relatives; they are often also the community's traditional birth attendants.

The type of operation to be performed is decided by the girl's mother or grandmother beforehand and payment is made to the excisor before, during and after the operation, to ensure the best service. This payment, partly in kind and partly in cash, is a vital source of livelihood for the excisors.

The conditions under which these operations take place are often unhygienic and the instruments used are crude and unsterilized. A kitchen knife, a razor-blade, a piece of glass or even a sharp fingernail are the tools of the trade. These instruments are used repeatedly on numerous girls, thus increasing the risk of blood-transmitted diseases, including HIV/AIDS.

The operation takes between 10 and 20 minutes, depending on its nature; in most cases, anaesthetic is not administered. The child is held down by three or four women while the operation is done. The wound is then treated by applying mixtures of local herbs, earth, cow-dung, ash or butter, depending on the skills of the excisor. If infibulation is performed, the child's legs are bound together to impair mobility for up to 40 days. If the child dies from complications, the excisor is not held responsible; rather, the death is attributed to evil spirits or fate. Throughout South-East Asia and urban African communities, FGM is becoming increasingly medicalized.

FGM is known to be practised in at least 25 countries in Africa. Infibulation is practised in Djibouti, Egypt, some parts of Ethiopia, Mali, Somalia and the northern part of the Sudan. Excision and circumcision occur in parts of Benin, Burkina Faso, Cameroon, the Central African Republic, Chad, Côte d'Ivoire, the Gambia, the northern part of Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mauritania, Nigeria, Senegal, Sierra Leone, Togo, Uganda and parts of the United Republic of Tanzania.

Outside Africa, a certain form of female genital mutilation exists in Indonesia, Malaysia and Yemen. Recent information has revealed that the practice also exists in some European countries and Australia among immigrant communities.

FGM is a custom or tradition synthesized over time from various values, especially religious and cultural values. The reasons for maintaining the practice include religion, custom, decreasing the sexual desire of women, hygiene, aesthetics, facility of sexual relations, fertility, etc. In general, it can be said that those who preserve the practice are largely women who live in traditional societies in rural areas. Most of these women follow tradition passively.

In the countries where the practice exists, most women believe that, as good Muslims, for example, they have to undergo the operation. In order to be clean and proper, fit for marriage, female circumcision is a precondition. Among the Bambara in Mali, it is believed that, if the clitoris touches the head of a baby being born, the child will die. The clitoris is seen as the male characteristic of the woman; in order to enhance her femininity, this male part of her has to be removed. Among women in Djibouti, Ethiopia, Somalia and the Sudan, circumcision is performed to reduce sexual desire and also to maintain virginity until marriage. A circumcised woman is considered to be clean.

Establishing identity and belongingness is another reason advanced for the perpetuation of the practice. For example, in Liberia and Sierra Leone, groups of girls of 12 and 13 of the indigenous population undergo an initiation rite, conducted by an older woman "Sowie". This involves education on how to be a good wife or co-wife, the use of herbal medicine and the "secrets" of female society. It also involves the ritual of circumcision.

Health and psychological implications

The effects of female genital mutilation have short-term and long-term implications. Haemorrhage, infection and acute pain are the immediate consequences. Keloid formation, infertility as a result of infection, obstructed labour and psychological complications are identified as later effects. In rural areas where untrained traditional birth attendants perform the operations, complications resulting from deep cuts and infected instruments can cause the death of the child.

Most physical complications result from infibulation, although cataclysmic haemorrhage can occur during circumcision with the removal of the clitoris; accidental cuts to other organs can also lead to

heavy loss of blood. Acute infections are commonplace when operations are carried out in unhygienic surroundings and with unsterilized instruments. The application of traditional medicine can also lead to infection, resulting in tetanus and general septicaemia. Chronic infection can also lead to infertility and anaemia.

Haematocolpos, or the inability to pass menstrual blood (because the remaining opening is often too small), can lead to infection of other organs and also infertility.

Obstetric complications are the most frequent health problem, resulting from vicious scars in the clitoral zone after excision. These scars open during childbirth and cause the anterior perineum to tear, leading to haemorrhaging that is often difficult to stop. Infibulated women have to be opened, or deinfibulated, on delivery of their child and it is common for them to be reinfibulated after each delivery.

There has been little research in the area of the psychological implications of FGM, but evidence indicates that most children experience recurring nightmares.

In her recent book, *Cutting the Rose—Female Genital Mutilation: The Practice and its Prevention*,[3] Efua Dorkenoo reports that some evidence of psychological effects is emerging among the large immigrant communities now living in Europe, the Americas, Australia and New Zealand. Teenagers, in particular, are having to live in two very different cultures, where different values prevail. At school they move within the very liberal setting of the Western culture; at home they have to conform to values held by their parents. Some of these values often conflict. For some teenagers this is proving to be problematic. Girls who have been genitally mutilated have to come to terms with the fact that they are not like their classmates. Mood swings and irritability, a constant state of depression, and anxiety have all been noted among infibulated girls. A small number, upon reaching the age of consent, are being deinfibulated without their parents' knowledge and engaging in premarital relationships, thus validating the reasoning behind their parents' wishes to have the operation performed.

There are also reports of psychological and health problems suffered by women seeking medical assistance in Western medical facilities due to lack of knowledge regarding genital mutilation. Excised and infibulated women have special needs which have been ignored or dealt with on a trial-and-error basis. In Western countries, severe forms of FGM present challenges to midwives and obstetricians in providing

[3] London, Minority Rights Publications, 1994.

antenatal and post-natal care. For example, professionals need training to know how to deliver infibulated women. The provision of health care for women and girls who have been genitally mutilated should be appropriate and sensitive to their needs. Health promotion work through women's health services can develop appropriate information materials and actively contribute to outreach work and awareness raising.

B. Son preference and its implications for the status of the girl child

One of the principal forms of discrimination and one which has far-reaching implications for women is the preference accorded to the boy child over the girl child. This practice denies the girl child good health, education, recreation, economic opportunity and the right to choose her partner, violating her rights under articles 2, 6, 12, 19, 24, 27 and 28 of the Convention on the Rights of the Child.

Son preference refers to a whole range of values and attitudes which are manifested in many different practices, the common feature of which is a preference for the male child, often with concomitant daughter neglect. It may mean that a female child is disadvantaged from birth; it may determine the quality and quantity of parental care and the extent of investment in her development; and it may lead to acute discrimination, particularly in settings where resources are scarce. Although neglect is the rule, in extreme cases son preference may lead to selective abortion or female infanticide.

In many societies, the family lineage is carried on by male children. The preservation of the family name is guaranteed through the son(s). Except in a few countries (e.g. Ethiopia), a girl takes her husband's family name, dropping that of her own parents. The fear of losing a name prompts families to wish to have a son. Some men marry a second or a third wife to be sure of having a male child. Among many communities in Asia and Africa, sons perform burial rites for parents. Parents with no male child do not expect to have an appropriate burial to "secure their peace in the next world". In almost all religions, ceremonies are performed by men. Priests, pastors, sheikhs and other religious leaders are men of great status to whom society attaches great importance, and this important role for men obliges parents to wish for a male child. Religious leaders have a major involvement in the perpetuation of son preference.

Son preference is universal and not unique to developing countries or rural areas. It is a practice enshrined in the value systems of most societies. It thus dictates the value judgements, expectations and behaviour of family members.

Son preference is a transcultural phenomenon, more marked in Asian societies and historically rooted in the patriarchal system. In certain countries in the Asian region, the phenomenon is less prevalent than in others. Son preference is stronger in countries where patriarchy and patriliny are more firmly rooted. Tribal societies, which are matrilineal societies, tended to be more gender egalitarian until the advent of settled agriculture.

In almost all regions, the practice is rooted in culture and the economics of son preference, these factors playing a major role in the low valuation and neglect of female children. The practice of son preference emerged with the shift from subsistence agriculture, which was primarily controlled by women, to settled agriculture, which is primarily controlled by men. In the patrilineal landowning communities with settled agriculture which are prevalent in the Asian region, the economic obligations of sons towards parents are greater. The son is considered to be the family pillar, who ensures continuity and protection of the family property. Sons provide the workforce and have to bring in a bride—"an extra pair of hands". Sons are the source of family income and have to provide for parents in their old age. They are also the interpreters of religious teachings and the performers of rituals, especially on the death of parents, which include feeding a large number of people, sometimes several villages. As soldiers, sons protect the community and hold political power.

Son preference in the Asian region manifests itself either covertly or overtly. The birth of a son is welcomed with celebration as an asset, whereas that of a girl is seen as a liability, an impending economic drain. According to an Asian proverb, "bringing up girls is like watering the neighbour's garden".

Psychological and health consequences

The psychological effect of son preference on women and the girl child is the internalization of the low value accorded them by society. Scientific evidence of the deleterious effect of son preference on the health of female children is scarce, but abnormal sex ratios in infant and young child mortality rates, in nutritional status indicators and even in population figures show that discriminatory practices are wide-

spread and have serious repercussions. Geographically, there is often a close correspondence between the areas of strong son preference and of health disadvantage for females.

The areas most affected by the problem seem to be South Asia (Bangladesh, India, Nepal, Pakistan), the Middle East (Algeria, Egypt, Jordan, the Libyan Arab Jamahiriya, Morocco, the Syrian Arab Republic, Tunisia, Turkey) and parts of Africa (Cameroon, Liberia, Madagascar, Senegal). In Latin America, there is evidence of abnormal sex ratios in mortality figures in Ecuador, Mexico, Peru and Uruguay.

Discrimination in the feeding and care of female infants and/or higher rates of morbidity and malnutrition have been reported in most of the countries already listed and also in Bolivia, Colombia, the Islamic Republic of Iran, Nigeria, the Philippines and Saudi Arabia. More than two thirds of the world's population live in countries where registration of death does not occur and many more live in countries where death rates are not published by sex. Moreover, discrimination against girls has to be extreme to emerge in mortality rates. For every growing girls who dies, there are many whose health and potential for growth and development are permanently impaired. Countless reports the world over have demonstrated that, in societies where son preference is practised, the health of the female child is adversely affected.

In some communities in the Asian region where son preference is highly marked, efforts to differentiate a female child from a male child through various socio-economic norms and practices start as early as the foetal stage and continue throughout the entire life cycle. In these communities, amniocentesis tests and sonography for sex determination have resulted in the abortion of female foetuses. The introduction and expansion of scientific methods of sex detection have led to a revival of female foeticide and infanticide.

Education

Access to education by itself is not enough to eliminate values held by society, for such values are in most countries transmitted into educational curricula and textbooks. Women are thus still depicted as passive and domestically oriented, while men are depicted as dominant and as breadwinners.

Education does, however, offer the female child an improved opportunity to be less dependent on men in later life. It increases her prospects of obtaining work outside the home. As laid down in articles 28 and 29 of the Convention on the Rights of the Child, all

children have the right to education, and the content of such education should be directed to the development of the child's personality, talents and mental and physical abilities to their fullest potential.

According to the United Nations Children's Fund (UNICEF), the expansion of educational opportunities over the past several decades has clearly affected girls, although this has not been a result of deliberate policy to reduce gender disparities in educational access. Girls' education, measured by gross primary school enrolment ratios, has improved substantially in the Middle East and North Africa region, for example. Nevertheless, in 1990, the region still had 44 million illiterate mothers, a large and increasing backlog left over from times of lower enrolment levels. Differences in primary school enrolment levels for boys and girls and competition between them are still very significant in a number of countries. In countries where overall enrolment is much lower than desired, girls are particularly disadvantaged.

Although in many countries school drop-out rates are steadily falling, they continue to be higher among girls than among boys. The reasons for the high drop-out rate among girls are poverty, early marriage, helping parents with housework and agricultural work, the distance of schools from homes, the high costs of schooling, parents' illiteracy and indifference, and the lack of a positive educational climate. Girls begin school very late and withdraw with the onset of puberty. Parents do not see the benefits of girls' education because girls are given away in marriage to serve the husband's family. Sons are given priority. In certain countries, enrolment rates for girls have actually declined despite attempts to increase them.

Recreation and work opportunities

According to article 31, paragraph 1, of the Convention on the Rights of the Child, States parties "recognize the right of the child to rest and leisure, to engage in play and recreational activities". However, from an early age, girls from rural and poor urban homes are burdened with domestic tasks and child care, which leaves them no time to play. Studies have shown that recreation plays a vital part in a child's emotional and mental development. When time for play is found by girls, it often takes place near the home. Young boys, however, have fewer demands made of them and are allowed to engage in activities outside the home. The status of girls is linked to that of women and their exploitation. A woman's work never ends, especially in rural areas and in poor urban households.

The Convention on the Elimination of All Forms of Discrimination against Women calls for the elimination of discrimination against women in the field of employment, "in order to ensure, on a basis of equality of men and women, the same rights" (art. 11, para. 1). It also calls upon States to ensure that women in rural areas have access to agricultural credit and loans, marketing facilities, appropriate technology and equal treatment in land and agrarian reform (art. 14, para. 2 (*g*)). Evidence indicates, however, that as girls grow older they face discriminatory treatment in gaining access to economic opportunities. Major inequalities persist in employment, access to credit, inheritance rights, marriage laws and other socio-economic dispensations. Compared with men, women have fewer opportunities for paid employment and less access to skill training that would make such employment possible. Women are usually restricted to low-paid and casual jobs, or to informal activities.

Landlessness has increased among women, and the number of women cultivators has declined in some regions, partly due to increased mechanization of agriculture. An increasing number of women in most developing countries are occupied in the informal, invisible sectors where national social and labour legislation on maternity benefits, equal wages and crèche facilities does not apply.

C. Female infanticide

Sex bias or son preference places the female child in a disadvantageous position from birth. In some communities, however, particularly in Asia, the practice of infanticide ensures that some female children have no life at all, violating the basic right to life laid down in article 6 of the Convention on the Rights of the Child. Selective abortion, foeticide and infanticide all occur because the female child is not valued by her culture, or because certain economic and legislative acts have ruled her life worthless.

In India, for example, infanticide was formally legislated against during British rule, after centuries of practice in some communities. However, recent reports have shown that there is a revival.

In certain parts of India and Pakistan, women are still considered unnecessary evils. In the past, when victorious armies took their revenge on defeated communities, women were raped as part of the spoils of war. Subsequently, these communities resorted to killing their daughters at birth or when the enemy was advancing, to spare the female population and community from shame.

Modern techniques such as amniocentesis and ultrasound tests have given women greater power to detect the sex of their babies in time to abort. Illegal abortion, particularly of female foetuses, either self-inflicted or performed by unskilled birth attendants, under poor sanitary conditions has led to increased maternal mortality, particularly in South and South-East Asia.

Female foeticide is an emerging problem in some parts of India, and the Government has introduced a bill in Parliament to ban the use of amniocentesis for sex-determination purposes. Such misuse of amniocentesis is also prohibited in the States of Maharashtra, Punjab, Rajasthan and Haryana, where the problem is more prevalent.

D. Early marriage and dowry

Early marriage is another serious problem which some girls, as opposed to boys, must face. The practice of giving away girls for marriage at the age of 11, 12 or 13, after which they must start producing children, is prevalent among certain ethnic groups in Asia and Africa. The principal reasons for this practice are the girls' virginity and the bride-price. Young girls are less likely to have had sexual contact and thus are believed to be virgins upon marriage; this condition raises the family status as well as the dowry to be paid by the husband. In some cases, virginity is verified by female relatives before the marriage.

Child marriage robs a girl of her childhood—time necessary to develop physically, emotionally and psychologically. In fact, early marriage inflicts great emotional stress as the young woman is removed from her parents' home to that of her husband and in-laws. Her husband, who will invariably be many years her senior, will have little in common with a young teenager. It is with this strange man that she has to develop an intimate emotional and physical relationship. She is obliged to have intercourse, although physically she might not be fully developed.

Girls from communities where early marriages occur are also victims of son preferential treatment and will probably be malnourished, and consequently have stunted physical growth.

Neglect of and discrimination against daughters, particularly in societies with strong son preference, also contribute to early marriage of girls. It has been generally recognized at United Nations seminars on traditional practices affecting women and children, and on the basis of research, that early marriage devalues women in some societies and

that the practice continues as a result of son preference. In some countries, girls as young as a few months old are promised to male suitors for marriage. Girls are fattened up, groomed, adorned with jewels and kept in seclusion to make them attractive so that they can be married off to the highest bidder.

Health complications that result from early marriage in the Middle East and North Africa, for example, include the risk of operative delivery, low weight and malnutrition resulting from frequent pregnancies and lactation in the period of life when the young mothers are themselves still growing.

Another economic reason which perpetuates the practice of female genital mutilation is related to dowries.

The dowry price of a woman is her exchange value in cash, kind or any other agreed form, such as a period of employment. This value is determined by the family of the bride-to-be and her future in-laws. Both families must gain from the exchange. The woman's in-laws want an extra pair of hands and children; her family desire payment which will provide greater security for other relatives. The dowry price will be higher if the woman's virginity has been preserved, notably through genital mutilation.

In certain communities in South Asia, the low status of girls has to be compensated for by the payment of a dowry by the parents of the girl to the husband at the time of marriage. This has resulted in a number of dowry crimes, including mental and physical torture, starvation, rape, and even the burning alive of women by their husbands and/or in-laws in cases where dowry payments are not met.

It should be noted that the Committee on the Rights of the Child, in a number of recommendations in the light of article 2 of the Convention on the Rights of the Child, has called upon States to recognize the principle of equality before the law and forbid gender discrimination, including the adoption of legislation prohibiting harmful traditional practices such as genital mutilation, forced and early marriage of girl children, early pregnancy and related prejudicial health practices.

The work of the Committee has also permitted the identification of certain areas where law reform should be undertaken, in both civil and penal areas, such as the minimum age for marriage and establishment of the age of criminal responsibility as being the attainment of puberty. Some States have argued that girls attain their physical maturity earlier, but it is the view of the Committee that maturity cannot simply be identified with physical development when social and mental development are lacking and that, on the basis of such criteria, girls

are considered adults before the law upon marriage, thus being deprived of the comprehensive protection ensured by the Convention on the Rights of the Child. The International Conference on Population and Development, held at Cairo in September 1994 (see p. 36 below), encouraged Governments to raise the minimum age for marriage. In her preliminary report to the Commission on Human Rights, the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, also recognized that the age of marriage was a factor contributing to the violation of women's rights (E/CN.4/ 1995/42, para. 165).

E. Early pregnancy, nutritional taboos and practices related to child delivery

Early pregnancy can have harmful consequences for both young mothers and their babies. According to UNICEF, no girl should become pregnant before the age of 18 because she is not yet physically ready to bear children. Babies of mothers younger than 18 tend to be born premature and have low body weight; such babies are more likely to die in the first year of life. The risk to the young mother's own health is also greater. Poor health is common among indigent pregnant and lactating women.

In many parts of the developing world, especially in rural areas, girls marry shortly after puberty and are expected to start having children immediately. Although the situation has improved since the early 1980s, in many areas the majority of girls under 20 years of age are already married and having children. Although many countries have raised the legal age for marriage, this has had little impact on traditional societies where marriage and child-bearing confer "status" on a woman.

Those who start having children early generally have more children, at shorter intervals, than those who embark on parenthood later. Fertility rates have been falling over the past decade, but they remain very high in Africa, parts of Latin America and Asia. Once again, the link between delayed child-bearing and education is crucial.

An additional health risk to young mothers is obstructed labour, which occurs when the baby's head is too big for the orifice of the mother. This provokes vesicovaginal fistulas, especially when an untrained traditional birth attendant forces the baby's head out unduly.

Generally throughout the developing world, the average food intake of pregnant and lactating mothers is far below that of the average male. Cultural practices, including nutritional taboos, ensure that pregnant women are deprived of essential nutriments, and as a result they tend to suffer from iron and protein deficiencies.

Poor health can be improved by a more balanced diet. The choice of food consumed is determined by a number of factors, including availability of natural resources, economics, religious beliefs, social status and traditional taboos. Because these factors place limits in one way or another on the intake of food, communities and individuals are deprived of essential nutriments and, as a result, physical and mental development is impaired. This is generally the case in most developing countries, but especially throughout Africa.

Although poor distribution of resources—whether due to harsh geographical or climatic conditions in a region, or to poverty resulting from a lack of purchasing power—contributes greatly to the severe imbalance of diets throughout Africa, taboos placed on food for religious or cultural reasons are an unnecessary practice which exacerbates the situation.

The reasons for such taboos are many, but all are steeped in superstition. Many taboos are upheld because it is believed that the consumption of a particular animal or plant will bring harm to the individual.

Permanent taboos are also placed on female members of most communities throughout Africa. From infancy, the female child is given a low-nutrition diet. She is weaned at a much earlier age than the male infant, and throughout her life she will be deprived of high-protein food such as animal meat, eggs, fish and milk. As a result, the intake of nutriments by the female population is lower than that of the male population.

Temporary taboos which are applicable only at certain times in the life of an individual also affect women disproportionately. Most communities throughout Africa have food taboos specially for pregnant women. Often these taboos exclude the consumption of nutriments essential for the expectant mother and foetus.

These nutritional taboos are unnecessary impositions made on women, who are already malnourished. It is perhaps not surprising that maternal and infant mortality rates are so high and life expectancy low in the countries concerned. But nutritional taboos also have far-reaching implications for women in the field of work, where their levels of productivity can be affected.

Lack of basic knowledge of human bodily functions can lead to illogical conclusions when illness sets in, or especially when a mother or her infant dies. Surrounded by myths and superstition, what may be a simple mishap can be explained in much more sinister terms as the product of evil spirits or bad omens.

Most rural areas throughout the developing world have disproportionately fewer health centres and clinics, trained midwives, nurses and doctors than urban areas. For most rural dwellers, health treatment must be obtained from traditional birth attendants (TBAs). Most TBAs have no formal training in health practices but acquire their skills via apprenticeship. These are skills passed down through generations of women. By observing a given situation, the TBA learns which remedy to use for which illness, or how to perform different kinds of delivery. If the situation changes, they try to adapt their knowledge and remedies and hope that that works. If things go wrong, however, supernatural explanations are given; blame is never attributed to the TBA.

According to the World Health Organization (WHO), more than half the births in developing nations are attended by TBAs and relatives. Although these women have every good intention to assist their patients, mortality rates are higher in the rural areas where they operate.

The use of herbal mixtures and magic is common during delivery throughout Africa. The chemical components of some of these mixtures are beneficial, but others are quite lethal, especially when taken in large dosage.

In the case of obstructed labour, the abdomen is at times massaged or pressed to force the baby out. Some TBAs perform surgical operations to extract the foetus, using a knife or razor-blade to cut the labia minora and vaginal opening. A similar operation, known as the "Gishiri cut", is performed in some parts of Africa, and the likely complications are known to be haemorrhaging and infection.

Among the most bizarre treatments for obstructed labour are the psychological ones. In many societies, difficulty in labour or delay in delivery is believed to be punishment for marital infidelity. The woman is pressured to confess her misdeed so that labour may continue without complications. This practice, which inflicts great mental cruelty on a woman already in agony due to obstructed labour, is prevalent in several African countries. In addition to the psychological trauma suffered by the woman, the practice further delays her being taken to hospital.

Treatment of obstructed labour by ineffective and harmful traditional methods can also cause uterine rupture. Rupture of the uterus still constitutes one of the major causes of maternal death in obstetric

practice in developing countries. Death rates as high as 37 per cent have been reported in studies of hospitalized women with ruptured uterus. Foetal mortality is also very high: it was 100 per cent in a study of 144 cases of uterine rupture in one African country and 96 per cent in an Indian review of 181 cases.

Even when obstructed labour does not result in maternal death, it leads to prolonged or even permanent ill health in the majority of cases. For example, vesicovaginal fistula is a condition that has traumatic physical as well as social consequences. Due to prolonged pressure on the bladder during obstructed labour, the lower genital tract is severely damaged, causing a false passage between the bladder and the vagina. The woman suffers from incontinence of urine and sometimes of faeces as well, since 10 to 15 per cent of all vesicovaginal fistula cases have associated rectovaginal fistula.

In two African countries, a practice known as "Zur Zur" is performed on women between the 34th and 35th weeks of their first pregnancy. A deep cut is made in the anterior wall of the vagina, sometimes on the posterior wall. The wound is allowed to bleed, then the woman rests for a while before being sent home to nurse her wound. The purpose of this operation is to prepare the woman for an easy delivery. However, the consequences can be death through excessive bleeding, shock, infection of the birth canal, and vesicovaginal or vaginal fistula.

Misdiagnoses have been made by midwives and doctors who receive these women once complications set in. The bleeding is often mistaken for an ante-partum haemorrhage, and Caesarean sections have been performed; but invariably the bleeding continues. Midwives are fighting to get the practice stopped in the countries concerned.

Various forms of contraception and methods of tightening the vagina are practised throughout the world. Many involve inserting herbal mixtures and foreign objects—for example, aluminium hydroxide, cloth, stone, soap and lime—into the vagina. Many of these inserts have an irritating or erosive effect on the vaginal mucosa, which is a natural defence against infections and disease, such as HIV.

F. Violence against women

Most of the practices reviewed so far constitute acts of violence against women or the girl child by the family and the community, and are often condoned by the State. In its resolution 1994/45 of 4 March 1994, the Commission on Human Rights recognized other forms of

non-traditional practices, such as rape and domestic violence, as violence against women. In that resolution (paras. 6 and 8), the Commission decided to appoint, for a three-year period, a special rapporteur on violence against women, including its causes and consequences. Ms. Radhika Coomaraswamy of Sri Lanka was subsequently appointed Special Rapporteur on violence against women.

This appointment came after more than two decades of tireless campaigning by women worldwide. An important step marked by resolution 1994/45 was that, for the first time, Governments were held accountable for acts of violence against women committed by the private individual.

In the same resolution (para. 7), the Commission invited the Special Rapporteur, in carrying out her mandate, and within the framework of the Universal Declaration of Human Rights and all other international human rights instruments, including the Convention on the Elimination of All Forms of Discrimination against Women and the Declaration on the Elimination of Violence against Women, *inter alia*, to recommend measures, at the national, regional and international levels, to eliminate violence against women and its causes, and to remedy its consequences.

The Special Rapporteur's mandate includes carrying out field missions, either separately or jointly with other special rapporteurs and working groups, and consulting periodically with the Committee on the Elimination of Discrimination against Women. In addition, the Commission requested the Secretary-General to ensure that the reports of the Special Rapporteur are brought to the attention of the Commission on the Status of Women.

The Special Rapporteur submitted a preliminary report to the Commission on Human Rights at its fifty-first session, in 1995 (E/CN.4/1995/42).

II. Review of action and activities by United Nations organs and agencies, Governments and NGOs

A. United Nations organs and agencies

Action on traditional practices affecting the health of women and children, in particular female genital mutilation (FGM), was first taken in 1958 when the Economic and Social Council (ECOSOC) invited the World Health Organization (WHO) to undertake a study of the persistence of customs subjecting girls to ritual operations and to communicate the results of the study to the Commission on the Status of Women.

In 1960, the issue of FGM was debated at the Seminar on the Participation of Women in Public Life, held at Addis Ababa for the African region. Concluding remarks included a call to WHO to make a statement condemning all forms of medicalization of FGM. In its resolution 821 II (XXXII), adopted in July 1961, ECOSOC again invited WHO to study the medical aspects of operations based on customs. A seminar convened in 1979 by the WHO Regional Office for the Eastern Mediterranean in Khartoum marked a milestone in the campaign against harmful traditional practices, setting the pace and direction for international and national plans of action. Additional forms of harmful traditional practices were identified and a recommendation was made for the formation of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children. In addition, the seminar reiterated the concluding remarks made at the 1960 seminar and urged Governments to collaborate with international bodies in a concerted effort to eliminate these practices.

Commission on Human Rights and Sub-Commission on Prevention of Discrimination and Protection of Minorities

For a number of years, many voices, both national and international, have been echoing the United Nations call for an end to the suffering of girls and women caused by harmful traditional practices. In

the 1980s, the campaign against such practices became so widespread that, in 1983, the issue was taken up by the Sub-Commission on Prevention of Discrimination and Protection of Minorities. The Sub-Commission's recommendation that a working group be established to conduct a study of all aspects of the problem was endorsed by the Commission on Human Rights and the Economic and Social Council.

The Working Group on Traditional Practices Affecting the Health of Women and Children, composed of experts designated by the Sub-Commission on Prevention of Discrimination and Protection of Minorities, UNICEF, UNESCO and WHO, and representatives of concerned NGOs, held three sessions in Geneva during 1985 and 1986. The report of the Working Group (E/CN.4/1986/42) was submitted to the Commission on Human Rights at its forty-second session, in 1986.

By its resolution 1988/57 of 9 March 1988, the Commission on Human Rights requested the Sub-Commission to consider measures to be taken at the national and international levels to eliminate the practices in question, and to report to the Commission on the subject. Pursuant to that request, the Sub-Commission appointed one of its members, Mrs. Halima Embarek Warzazi, as Special Rapporteur to study, on the basis of information to be gathered from Governments, specialized agencies, other intergovernmental organizations and concerned NGOs, recent developments relating to traditional practices affecting the health of women and children (Sub-Commission resolution 1988/34 of 1 September 1988).

The Special Rapporteur submitted a preliminary report (E/CN.4/Sub.2/1989/42 and Add.1) and a final report (E/CN.4/Sub.2/1991/6), containing information received from the above-mentioned sources, as well as information gathered during field missions to the Sudan and Djibouti. These field missions, together with two regional seminars on the subject organized by the Centre for Human Rights in Africa and Asia (Burkina Faso, 1991; Sri Lanka, 1994), have contributed to a better understanding of the phenomenon of harmful traditional practices which violate the rights of women and children.

Finally, in its resolution 1994/30 of 26 August 1994, the Sub-Commission adopted the Plan of Action for the Elimination of Harmful Traditional Practices Affecting the Health of Women and Children, which was prepared by the Sri Lanka regional seminar (see annex). In the same resolution, the Sub-Commission recommended the extension of the Special Rapporteur's mandate for an additional two years, to enable her to carry out an in-depth analysis of the issue, taking into consideration the conclusions and recommendations of the two regional seminars and the effects of the implementation of the Plan of Action.

The resolution also called upon the Secretary-General to transmit the Plan of Action to the International Conference on Population and Development, held at Cairo in September 1994, and to the Fourth World Conference on Women, to be held at Beijing in September 1995. The Special Rapporteur was requested to submit reports at the forty-seventh and forty-eighth sessions of the Sub-Commission, in 1995 and 1996, respectively. The Sub-Commission's recommendations were endorsed by the Commission on Human Rights in its decision 1995/112 of 3 March 1995.

Committee on the Elimination of Discrimination against Women

At its ninth session, in 1990, the Committee on the Elimination of Discrimination against Women addressed the issue of harmful traditional practices, in particular FGM. In general recommendation No. 14 adopted at that session, it indicated its recognition of work carried out by women's organizations in identifying and combating harmful traditional practices. The Committee recommended that Governments support those efforts and encourage politicians, professionals, and religious and community leaders at all levels, including the media and the arts, to cooperate in influencing attitudes towards the eradication of FGM. The Committee also called for the introduction of appropriate educational and training programmes and seminars based on research findings about the problems arising from FGM.

The same general recommendation urged Governments to:

. . .

(*b*) Include in their national health policies appropriate strategies aimed at eradicating [FGM] in public health care . . . [including] the special responsibility of . . . traditional birth attendants . . . ;

(*c*) Invite assistance, information and advice from the appropriate organizations of the United Nations system to support and assist efforts being deployed to eliminate harmful traditional practices;

(*d*) Include in their reports to the Committee under articles 10 and 12 of the Convention on the Elimination of All Forms of Discrimination against Women information about measures taken to eliminate [FGM].

United Nations Children's Fund

The United Nations Children's Fund (UNICEF) has supported a wide range of programme activities for the advancement of women and

girls through advocacy, policy-oriented research and technical cooperation. There are many examples in the sectors of health, education, income generation and water supply and sanitation of projects successfully addressing the needs of women and girls and promoting their participation in community development.

Special attention is given to the girl child and to the need to reduce disparities in the treatment of boys and girls. The Convention on the Rights of the Child and related policy efforts have stimulated regional and country-level action for advocacy and mobilization in favour of girls and for the elimination of discriminatory social and cultural practices. Social mobilization has focused on changing attitudes, particularly those related to the preference for sons in most countries in Africa, Asia, the Caribbean and Latin America. UNICEF's national, regional and international advocacy of appropriate policies and its efforts to bring about attitudinal and behavioural change, especially in such critical areas as early marriage, female genital mutilation, teenage pregnancy and female infanticide, will be intensified through support to local and national groups and organizations concerned with these issues.

In May 1994, UNICEF's Executive Board requested the Executive Director to give high priority to a number of efforts to promote gender equality and gender-sensitive development programmes, taking into account the special needs of individual countries and, *inter alia*, the provisions of the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women. The priorities for action include:

(*a*) strengthening the integration of gender concerns in country programmes by eliminating the disparities which exist at each stage of the life cycle of girls and women;

(*b*) promotion of ratification and implementation of the Convention on the Elimination of All Forms of Discrimination against Women, as well as the Convention on the Rights of the Child;

(*c*) support for specific action and strategies which promote gender equality within the family, including the sharing of parental responsibilities.

UNICEF country offices are working closely with NGO partners and Governments, as well as with other groups, including women's organizations, religious leaders, health workers and teachers.

World Health Organization

The World Health Organization (WHO) has been concerned with the issue of harmful traditional practices since 1958, when ECOSOC requested a study of the health implications of FGM. At a seminar in 1979, organized by the WHO Regional Office for the Eastern Mediterranean in Khartoum (see p. 24 above), WHO condemned FGM as a serious health risk which should be abolished, and called upon medical personnel to refrain from performing FGM.

WHO promotes and supports traditional practices which enhance health—for example, breast-feeding—and discourages those which are harmful, particularly to the health of women and girls. Among the latter, female genital mutilation presents the most dramatic risk of ill health, affecting some 75 million women and girls in Africa alone. The organization also discourages nutritional taboos which prevent pregnant and lactating women from eating essential foods. WHO works closely with all concerned national authorities, and particularly with non-governmental organizations, on these issues.

In 1993, the Forty-sixth World Health Assembly adopted resolution WHA46.18 on maternal and child health and family planning for health. The resolution expressed concern, *inter alia*, about the continuing inequities affecting women in general and the persistence of harmful traditional practices such as child marriages, dietary limitations during pregnancy, and FGM. It urged member States to continue to monitor and evaluate the effectiveness of their efforts to achieve the goal of health for all, in particular in eliminating traditional practices affecting the health of women, children and adolescents.

In 1994, the Forty-seventh World Health Assembly adopted resolution WHA47.10, dealing specifically with harmful traditional practices, in which it urged all member States (para. 2):

> (1) to assess the extent to which harmful traditional practices affecting the health of women and children constitute a social and public health problem in any local community or subgroup;
>
> (2) to establish national policies and programmes that will effectively, and with legal instruments, abolish female genital mutilation, child-bearing before biological and social maturity, and other harmful practices affecting the health of women and children;
>
> (3) to collaborate with national non-governmental groups active in this field, draw upon their experience and expertise and, where such groups do no exist, encourage their establishment;

In the same resolution, the Assembly requested the Director-General of WHO to strengthen technical support to member States in implementing the above measures; and to continue global and regional collaboration with non-governmental organizations, United Nations bodies, and other agencies and organizations concerned in order to establish national, regional and global strategies for the abolition of harmful traditional practices.

B. Governments

The preliminary report (E/CN.4/Sub.2/1989/42 and Add.1) and final report (E/CN.4/Sub.2/1991/6) of the Special Rapporteur on traditional practices affecting the health of women and children contain summaries of information on the topic received, in response to requests by the Secretary-General, from 28 Governments. However, many of these Governments stated that harmful traditional practices were unknown in their countries. Others recognized the existence of some such practices, namely female genital mutilation (FGM), son preference and inferior social status of women, and practices related to marriage, pregnancy and nutrition.

A number of countries throughout the world have either taken or supported action to prevent traditional practices affecting the health of women and children, in particular FGM.

Bangladesh clearly upholds the principle of equality of men and women and prohibits discrimination against women. To protect the legal rights of women and to stop violence and repression against them, the Government has adopted the following legislation:

(a) *Dowry Prohibition Act, 1980*, which provides for punishment for giving, taking or abetting the giving or taking of dowry;

(b) *Cruelty to Women (Deterrent Punishment) Ordinance, 1983*, which provides for punishment for abduction of women for unlawful purposes, trafficking in women, or causing or attempting to cause death or grievous harm to a wife for dowry;

(c) *Child Marriage Restraint Act Amendment Ordinance, 1984*, which raises the marriageable age for women from 16 to 18 years, and for men from 18 to 21 years. It also provides for punishment for marrying or giving in marriage of a child;

(d) *Muslim Family Laws Ordinance, 1961* (as amended in 1982), which provides for increased punishment in cases of polygamy and divorce in violation of the statutory provisions.

In the *Sudan*, a law was passed in 1946, under the British Colonial Administration, to prohibit the practice of infibulation.

In *Sweden*, the *Act on Prohibition of Female Circumcision* was passed in 1982. It not only seeks to bring to justice those breaking Swedish laws, but also any person living in Sweden who assists in carrying out FGM in another country which also has prohibitive laws.

In the *United Kingdom*, the *Prohibition of Female Circumcision Act* was adopted in 1985. Measures against FGM have also been included in the child protection procedures at local authority levels.

In the *United States of America*, the *Federal Prohibition of Female Genital Mutilation Act* was under consideration by the House of Representatives in early 1995.

A number of countries which have not yet passed specific laws use existing national legislation to prohibit the practice of female genital mutilation.

In *France*, no specific law exists, but article 312-3 of the Penal Code is applied to prosecute persons exercising violence against or seriously assaulting a child under 15, "if the result has been mutilation, amputation or . . . loss of an eye or other permanent disabilities, or death not intentionally caused by the perpetrator". The Criminal Division of the Cour de cassation decided, by a judgement of 20 August 1983, that ablation of the clitoris resulting from wilful violence constituted a mutilation under article 312-3 of the Penal Code. While the term "female genital mutilation" is not used in the Penal Code, this decision makes it quite clear that such practices fall within the purview of the enactment.

In *Norway*, all hospitals were alerted in 1985 to the practice of female genital mutilation.

All the above Governments have also acknowledged the importance of education and awareness raising among both the practising communities and service providers. Practical steps are being taken in Australia, Belgium, Canada, Djibouti, Egypt, Finland, France, Germany, Italy, the Netherlands, Norway, Somalia, the Sudan, Sweden and the United Kingdom to ensure that relevant information is disseminated. Lack of information from Africa and Asia makes it difficult to ascertain what recent action has been taken at national and grass-roots levels.

Some African countries are in the process of formulating national legislation against FGM, including Burkina Faso, Djibouti, Egypt, Ghana and Nigeria. In Burkina Faso, Kenya and Senegal, statements have been made by heads of State expressing the need to eliminate FGM.

As regards Asia, the following countries reported on ongoing and planned action to eradicate harmful traditional practices at the second United Nations regional seminar on the subject, held in Sri Lanka in July 1994: China, India, Islamic Republic of Iran, Iraq, Malaysia, Nepal, Pakistan, Republic of Korea, Singapore, Sri Lanka and Thailand (E/CN.4/Sub.2/1994/10, paras. 75 ff.).

C. Non-governmental organizations

Available information indicates that increasingly more grassroots activities in the area of harmful traditional practices are taking place in Africa and Asia, as well as in Western countries. In Australia, Canada, Europe, New Zealand and the United States of America, the work of dedicated women is raising awareness and providing training and advice to service providers such as midwives, health visitors, nurses, doctors, teachers and social workers.

Of the 29 countries in Africa identified as having communities practising female genital mutilation, 24 have branches of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, in addition to many women's NGOs. Many established national women's organizations have carried out research and surveys, and others have ventured into communities where FGM and other harmful traditional practices prevail, setting up training programmes for excisors, traditional birth attendants and community members.

Work at this level is vital, for it is through the activities of NGOs that positive changes are being realized. Although early results of work in these communities are encouraging, to change a community's attitude totally will take at least a generation. The NGOs in question thus urgently need continuing financial support to ensure that their programmes are fully implemented.

Prominent non-governmental organizations

(*a*) Inter-African Committee on Traditional Practices Affecting the Health of Women and Children

The Inter-African Committee (IAC) was formed in pursuance of a recommendation made at the 1979 Khartoum seminar organized by WHO (see p. 24 above). The Committee was officially established in

1984, following a regional seminar on harmful traditional practices held that year at Dakar, Senegal. The Committee has been granted consultative status with ECOSOC.

The aims of IAC are to reduce the morbidity and mortality rates for women and children through the eradication of harmful traditional practices; to promote traditional practices which are beneficial to the health of women and children; to play an advocacy role by promoting the importance of action against harmful traditional practices at the international, regional and national levels; and to raise funds for and support local activities of national committees and other partners.

The main areas of focus of IAC are training in information campaigns, and training of local activists and traditional birth attendants.

Intensive health education workshops, enhanced by the use of visual aids, are provided for local activists throughout communities, the objective being to raise awareness of issues related to harmful traditional practices. After five months of training, these activists are ready to go back to their communities and train other community members. In this way, the information on harmful traditional practices reaches a wide audience.

Traditional birth attendants are also trained to become active in the campaign against harmful traditional practices. Educational materials are disseminated to community groups such as students, youth groups, teachers, and religious and community leaders.

IAC also organizes international and regional seminars and workshops and is in close collaboration with the Organization of African Unity, the Economic Commission for Africa and other United Nations agencies, as well as with other intergovernmental organizations, NGOs, funding bodies and individuals. The objective is to appraise and share experience and ideas in methods of good practice. The last seminar took place in April 1994 at Addis Ababa, Ethiopia.

(*b*) FORWARD International

FORWARD International (Foundation for Women's Health Research and Development) has been operational since 1983. It emerged from the Minority Rights Group (United Kingdom), an international human rights organization, as a special project unit. FORWARD'S aim is to promote good health among African women and children internationally. Its main focus is information provision, advocacy, training of service providers, counselling and networking with other groups internationally.

FORWARD is a United Kingdom-based charity. It cooperates with community groups to develop educational materials on the health aspects of FGM, and it works very closely with local authorities in the area of child protection, by providing training to social workers and teachers. FORWARD also provides training for health professionals and gives advice on policy guidelines. The organization is co-founder of a specialized Well Woman Clinic based in the United Kingdom, which provides services and advice to excised and infibulated women.

FORWARD was instrumental at the national level in the formulation of the United Kingdom's 1985 *Prohibition of Female Circumcision Act*, as well as legislation on child protection. At the international level, FORWARD has provided advice and guidelines to legislators in relation to the drafting of national laws on FGM in the United States of America and Australia. The organization has worked closely with and addressed meetings organized by WHO, Amnesty International UK and other international agencies. In Africa, FORWARD has extensive links with women's groups working in the areas of health and FGM.

(*c*) Babiker Badri Scientific Association for Women's Studies

This organization was established in the Sudan in 1979 by a group of volunteer women in order to enhance research and education on women's issues. It is linked to the Ahfad College for Women, which is also controlled by the Babiker Badri Association. The organization is one of the pioneers in the fight against female genital mutilation, organizing seminars, workshops and studies on the subject. It runs an income-generating project for mothers in which education on FGM is gradually introduced. The Ahfad College for Women, which has more than 3,000 female students, has integrated education on FGM into its curriculum.

(*d*) Sudan National Committee on Traditional Practices

The main objective of this national women's organization is to educate and raise awareness of harmful traditional practices at all levels of society. The Committee has recognition and support from United Nations agencies, such as UNICEF, and other international bodies concerned with the health of children.

The Committee's main target groups are individuals who play influential roles in communities where FGM prevails, e.g. policy makers, service providers, and religious and community leaders. The Committee disseminates information via seminars, workshops, discussion groups and training sessions.

(*e*) Women for the Abolition of Sexual Mutilation (CAMS)

CAMS (Commission Internationale pour l'Abolition des Mutilations Sexuelles) was established in France in 1980; its head office is in Dakar, Senegal.

One prominent member of CAMS (France) has devoted her time to campaigning throughout practising communities in France. As a lawyer, she seeks to protect the girl child by implementing existing French law, which has involved prosecuting parents and excisors who have performed FGM in France. Like other NGOs working in this field, CAMS has a focus on research and awareness raising. It has also hosted a number of successful international seminars.

(*f*) Rädda Barnen

Rädda Barnen is the Swedish Save the Children organization. It has worked tirelessly with numerous women's groups in Africa and throughout Europe, providing vital financial support and advice.

D. United Nations seminars and conferences

(a) *Regional seminars*

Two regional seminars on traditional practices affecting the health of women and children have been organized in Africa and Asia by the United Nations under its programme of advisory services in the field of human rights. The first was held at Ouagadougou, Burkina Faso, from 29 April to 3 May 1991; the second was held at Colombo, Sri Lanka, from 4 to 8 July 1994.

The objectives of the seminars were to assess the human rights implications of harmful traditional practices, and to gather information from participants on measures taken at the governmental and non-governmental levels to end those practices. Participants included representatives of national Governments, United Nations agencies, and intergovernmental and non-governmental organizations. Both seminars provided the opportunity for participants to exchange information and experience. Participants were also urged to implement the recommendations of the seminars.

The recommendations adopted by the Ouagadougou seminar (E/CN.4/Sub.2/1991/48, paras. 136-138) included the following:

(i) *Governments* should:

Ratify and implement international instruments, including those relating to the protection of women and children;

Adopt legislation prohibiting practices harmful to the health of women and children, particularly FGM, and create a governmental body to implement the official policy adopted;

Carry out a survey and review of school curricula and textbooks with a view to eliminating prejudices against women;

Establish a national committee to combat harmful traditional practices, particularly FGM;

Cooperate with religious institutions and their leaders and other traditional authorities in order to eliminate harmful traditional practices such as FGM.

(ii) At the *international level*, the recommendations addressed specific United Nations bodies and agencies, including:

The Commission on the Status of Women, which was encouraged to study the issues pertaining to harmful traditional practices, particularly FGM;

UNICEF, which was called upon to continue its contribution to the campaign against FGM;

UNESCO, which was requested to provide assistance to the States concerned in preparing teaching materials, and to include the question of traditional practices in functional literacy programmes.

In addition, a special recommendation was addressed to all United Nations specialized agencies to include in their government aid programmes activities relating to the campaign against FGM.

(iii) *NGOs* were encouraged to intensify their activities for the elimination of harmful traditional practices. In particular, international NGOs concerned with protecting the health of women and children were requested to extend their financial and material support to national NGOs; private donors were also encouraged to support such activities. Finally, NGOs and Governments were urged to cooperate with each other in developing programmes for the retraining of FGM practitioners.

The recommendations of the Colombo seminar (E/CN.4/Sub.2/1994/10, paras. 89-90) were incorporated in the Plan of Action for the Elimination of Harmful Traditional Practices Affecting the Health of Women and Children, adopted by the seminar, the text of which is reproduced in the annex to this Fact Sheet.

The success of the two regional seminars has stimulated great interest among researchers and women activists the world over, thus increasing the volume of work being done and the information available on harmful traditional practices. This is an important step in understanding the prevalence and cultural justifications of the practices in question.

(b) *International Conference on Population and Development*

The International Conference on Population and Development, convened by the United Nations, was held in Cairo from 5 to 13 September 1994. Its main objective was to emphasize the direct links between reproductive health and human rights, thus placing the concerns of women and the girl child at the centre of the conference themes.

Concern over population explosion again prompted participants to examine the crucial causes of large families. Poverty, lack of family planning, poor health, limited access to education and lack of women's rights were identified as the main factors in that regard.

It was also pointed out that early marriage and pregnancy, leading to high fertility and poor sexual and reproductive health, prevented the girl child from pursuing fully her education and employment opportunities. The Conference reaffirmed that investment in the girl child's health, nutrition and education from infancy was crucial to development. The Conference further emphasized that there was a need to eliminate all forms of discrimination against the girl child—for example, son preference—which resulted in harmful and unethical practices such as prenatal sex selection and female infanticide.

The Conference urged Governments to increase public awareness of the value of girl children through public education, promoting equal treatment for girls and boys at all levels. It was emphasized that child marriages should be eliminated and arranged marriages discouraged. Respect for girls and women had to be instilled in boys from an early age. On the issue of FGM, Governments were urged to put a stop to the practice and to ensure that rehabilitation and counselling facilities were available for those concerned.

(c) *Fourth World Conference on Women*

The Fourth World Conference on Women will be held at Beijing from 4 to 15 September 1995. Convened by the United Nations, the Conference will adopt a Platform for Action—concentrating on

"critical areas of concern" that have been identified as obstacles to the advancement of women in the world—and set an agenda for the advancement of women at national, regional and international levels into the next century. The themes that have been identified include poverty, education, health, violence against women, the effects of armed or other kinds of conflict on women, and human rights of women.

The issue of traditional practices affecting the health of women and children has been raised at various regional meetings held in preparation for the Conference. The draft Platform for Action for the Conference makes specific mention of harmful traditional practices (E/CN.6/1995/2, annex, para. 88) and calls for increased public awareness about violence as a violation of women's human rights.

Conclusions

Most women in developing countries are unaware of their basic human rights. It is this state of ignorance which ensures their acceptance—and, consequently, the perpetuation—of harmful traditional practices affecting their well-being and that of their children. Even when women acquire a degree of economic and political awareness, they often feel powerless to bring about the change necessary to eliminate gender inequality. Empowering women is vital to any process of change and to the elimination of these harmful traditional practices.

Since the World Conference on Human Rights, held in Vienna in 1993, it is hoped that all States will recognize and accept the universality and indivisibility of the human rights of women. It is also expected that there will be more ratifications of the Convention on the Elimination of All Forms of Discrimination against Women. However, much remains to be done in the field of equality, taking into account the absence, in many countries, of real constitutional guarantees of fundamental human rights for all. The persistence of negative customary norms that conflict with and undermine implementation of both national legislation and international human rights standards must be addressed.

Although such national legislation and international standards are vital in tackling the issue of harmful traditional practices, there is an urgent need for a parallel programme that addresses the cultural environment from which these practices emerged, in order to eliminate the various justifications used to perpetuate them. It is the duty of States to modify the social and cultural attitudes of both men and women, with a view to eradicating customary practices based on the idea of the inferiority or superiority of either sex or on stereotyped roles of gender.

Comprehensive and intensive programmes of formal and informal education, awareness raising and training are the approach followed by some Governments, non-governmental organizations and women's groups. In part II.C above, reference was made to the various ways in which women's organizations are trying to empower women and service providers in an effort to change attitudes regarding harmful

traditional practices. This approach needs to be supported by implementation of national and international human rights norms relating to the elimination of discrimination against women. The environment of discrimination, which denies women and the girl child equal access to health care, education, employment and wealth, must also be addressed and reformed.

In the international debate, the father's responsibility towards the girl child has never been challenged. However, the duties and responsibilities of men within the family have begun to receive special attention as instruments of change. The Programme of Action adopted by the International Conference on Population and Development in September 1994 states:

> Changes in both men's and women's knowledge, attitudes and behaviour are necessary conditions for achieving the harmonious partnership of men and women. . . . It is essential to improve communication between men and women on issues of sexuality and reproductive health, and the understanding of their joint responsibilities, so that men and women are equal partners in public and private life.
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> . . .
>
> . . . Male responsibilities in family life must be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children.[4]

One of the most noticeable achievements at the international level has been the lifting of the taboo against addressing the issue of female genital mutilation, which is now acknowledged as a violation of the human rights of women and the girl child. This has created new sociocultural forces in the countries concerned, particularly among women participating in the crusade against FGM. None the less, unprecedented efforts are needed at the national and international levels to eradicate all forms of harmful traditional practices.

Governments, the United Nations and its specialized agencies, and NGOs should now play a more important role in monitoring and implementing the Plan of Action for the Elimination of Harmful Traditional Practices Affecting the Health of Women and Children (see annex). Technical and financial support should be given to national and regional organizations which advocate gender equality and promote human rights for all.

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[4] A/CONF.171/13, chap. I, resolution I, annex, paras. 4.24 and 4.27.

ANNEX

Plan of Action for the Elimination of Harmful Traditional Practices Affecting the Health of Women and Children[a]

A. National action

(1) A clear expression of political will and an undertaking to put an end to traditional practices affecting the health of women and girl children, particularly female genital mutilation, are required on the part of the Governments of countries concerned.

(2) International instruments, including those relating to the protection of women and children, should be ratified and effectively implemented.

(3) Legislation prohibiting practices harmful to the health of women and children, particularly female genital mutilation, should be drafted.

(4) Governmental bodies should be created to implement the official policy adopted.

(5) Governmental agencies established to ensure the implementation of the Forward-looking Strategies for the Advancement of Women adopted at Nairobi in 1985 by the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace should be involved in activities undertaken to combat harmful traditional practices affecting the health of women and children.

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[a] Prepared by the second United Nations Regional Seminar on Traditional Practices Affecting the Health of Women and Children, held at Colombo, Sri Lanka, from 4 to 8 July 1994 (E/CN.4/Sub.2/1994/10/Add.1 and Corr.1); adopted by the Sub-Commission on Prevention of Discrimination and Protection of Minorities in its resolution 1994/30 of 26 August 1994 (para. 3).

(6) National committees should be established to combat traditional practices affecting the health of young girls and women, particularly female genital mutilation, and governmental financial assistance provided to those committees.

(7) A survey and review of school curricula and textbooks should be undertaken with a view to eliminating prejudices against women.

(8) Courses on the ill effects of female genital mutilation and other traditional practices should be included in training programmes for medical and paramedical personnel.

(9) Instruction on the harmful effects of such practices should be included in health and sex education programmes.

(10) Topics relating to traditional practices affecting the health of women and children should be introduced into functional literacy campaigns.

(11) Audiovisual programmes (sketches, plays, etc.) should be prepared and articles published in the press on traditional practices adversely affecting the health of young girls and children, particularly female genital mutilation.

(12) Cooperation with religious institutions and their leaders and with traditional authorities is required in order to eliminate traditional practices such as female genital mutilation which are harmful to the health of women and children.

(13) All persons able to contribute directly or indirectly to the elimination of such practices should be mobilized.

Son preference

(14) The family being the basic institution from where gender biases emanate, wide-ranging motivational campaigns should be launched to educate parents to value the worth of a girl child, so as to eliminate such biases.

(15) In view of the scientific fact that male chromosomes determine the sex of children, it is necessary to emphasize that the mother is not responsible for selection. Governments must, therefore, actively attempt to change the misconceptions regarding the responsibilities of the mother in determining the sex of the child.

(16) Non-discriminatory legislation on succession and inheritance should be introduced.

(17) In the light of the dominant role religion plays in shaping the image of women in each society, efforts should be made to remove misconceptions in religious teachings which reinforce the unequal status of women.

(18) Governments should mobilize all educational institutions and the media to change negative attitudes and values towards the female gender and project a positive image of women in general, and the girl child in particular.

(19) Immediate measures should be taken by Governments to introduce and implement compulsory primary education and free secondary education and to increase the access of girls to technical education. Affirmative action in this field should be adopted in favour of the promotion of girls' education to achieve gender equity. Parents should be motivated to ensure the education of their daughters.

(20) Considering the importance of promoting self-esteem as a prerequisite for the higher status of women in the family and the community, Governments should take effective measures to ensure that women have access to and have control over economic resources, including land, credit, employment and other institutional facilities.

(21) Measures must be taken to provide free health care and services to women and children (in particular, girls) and to promote health consciousness among women, with emphasis on their own basic health needs.

(22) Governments should regularly conduct nutritional surveys, identify nutritional gender disparities and undertake special nutritional programmes in areas where malnutrition in various forms is manifested.

(23) Governments should also undertake nutritional education programmes to address, *inter alia*, the special nutritional needs of women at various stages of their life cycle.

(24) As son preference is often associated with future security, Governments should take measures to introduce a social security system, especially for widows, women-headed families and the aged.

(25) Governments are urged to take measures to eliminate gender stereotyping in the educational system, including removing gender bias from the curricula and other teaching materials.

(26) Governments should encourage by all means the activities of non-governmental organizations concerned with this problem.

(27) Public opinion makers, national institutions, religious leaders, political parties, trade unions, legislators, educators, medical practitioners and all other organizations should be actively involved in combating all forms of discrimination against women and girls.

(28) Gender disaggregated data on morbidity, mortality, education, health, employment and political participation should be collected regularly, analysed and utilized for the formulation of policy and programmes for girls and women.

Early marriage

(29) Governments are urged to adopt legislative measures fixing a minimum age for marriage for boys and girls. As recommended by the World Health Organization, the minimum age for girls should be 18 years. Such legislative measures should be reinforced with necessary mechanisms for their implementation.

(30) Registration of births and deaths, marriages and divorces should be made compulsory.

(31) Health issues relating to sex and family-life education should be included in school curricula to promote responsible and harmonious parenthood and to create awareness among young people about the harmful effects of early marriage, as well as the need for education about sexually transmitted diseases, especially AIDS.

(32) The media should be mobilized to raise public awareness on the consequences of child marriage and other such practices and the need to combat them. Governments and women's activist groups could monitor the role of the mass media in this regard. All Governments should adopt and work towards "safe motherhood" initiatives.

(33) Effective training programmes should be ensured for traditional birth attendants and paramedical personnel to equip them with the necessary skills and knowledge, including concerning the effects of harmful traditional practices, to provide care and services during the antenatal, child delivery and postnatal periods, especially for rural mothers.

(34) Governments should promote male contraception, as well as female contraception.

(35) To discourage the early marriage of girls, Governments should make provision to increase vocational training, retraining and apprenticeship programmes for young women to empower them economically. A certain percentage of the places in existing training institutions should be reserved for women and girls.

(36) Governments should recognize and promote the reproductive rights of women, including their right to decide on the number and spacing of their children.

(37) Considering that non-governmental organizations have an effective role in urging Governments to enhance women's health status and in keeping international organizations informed about the trends relating to traditional practices affecting the health of women and children, they should continue to report on the progress made and obstacles encountered in this area.

Child delivery practices

(38) Contraception should be encouraged as a means of promoting the health of women and children rather than as a means of achieving demographic goals.

(39) Governments should eliminate, through educational and legislative measures and the creation of monitoring mechanisms, all forms of harmful traditional childbirth practices.

(40) Governments should expand and improve health services and introduce training programmes for traditional birth attendants to upgrade their positive traditional skills, as well as to give them new skills on a priority basis.

(41) Research and documentation are essential to assess the harmful effects of certain traditional birth-related practices and to identify and continue some positive traditions like breast-feeding.

Violence against women and girl children

(42) Violence against women and girl children is a global phenomenon which cuts across geographical, cultural and political boundaries and varies only in its manifestations and severity. Gender violence has existed from time immemorial and continues up to the present day. It takes covert and overt forms, including physical and mental abuse. Violence against women, including female genital muti-

lation, wife burning, dowry-related violence, rape, incest, wife battering, female foeticide and female infanticide, trafficking and prostitution, is a human rights violation and not only a moral issue. It has serious negative implications for the economic and social development of women and society and is an expression of the societal gender subordination of women.

(43) Governments should openly condemn all forms of violence against women and children, in particular girls, and commit themselves to confronting and eliminating such violence.

(44) To stop all forms of violence against women, all available media should be mobilized to cultivate a social attitude and climate against such totally unacceptable human behaviour.

(45) Governments should set up monitoring mechanisms to control depiction of any form of violence against women in the media.

(46) Violence being a form of social aberration, Governments should advocate the cultivation of a social attitude so that victims of violence do not suffer any continuing disability, feelings of guilt, or low self-esteem.

(47) Governments should enact and regularly review legislation for effectively combating all forms of violence, including rape, against women and children. In this connection, more severe penalties for acts of rape and trafficking should be introduced and specialized courts should be established to process such cases speedily and to create a climate of deterrence.

(48) Female infanticide and female foeticide should be openly condemned by all Governments as a flagrant violation of the basic right to life of the girl child.

(49) The hearing of cases of rape should be in camera and the details not publicized, and legal assistance should be provided to the victims.

(50) Traditional practices of dowry and bride-price should be condemned by Governments and made illegal. Acts of bride burning should likewise be condemned and a heavy penalty inflicted on the guilty.

(51) Families, medical personnel and the public should be encouraged to report and have registered all forms of violence.

(52) More and more women should be inducted in law enforcement machinery as police officers, judiciary, medical personnel and counsellors.

(53) Gender-sensitization training should be organized for all law enforcement personnel and such training should be incorporated in all induction and refresher courses in police training institutions.

(54) Mechanisms for networking and exchanges of information on violence should be established and strengthened.

(55) Governments should provide shelters, counselling and rehabilitation centres for victims of all forms of violence. They should also provide free legal assistance to victims.

(56) Governments must develop and implement a legal literacy campaign to improve the legal awareness of women, including dissemination of information through all available means, particularly NGO programmes, adult literacy courses and school curricula.

(57) Governments must promote research on violence against women and create and update databases on this subject.

(58) Community-based vigilance should be promoted regarding gender violence, including domestic violence.

(59) At the national level, Governments should promote and set up independent, autonomous and vigilant institutions to monitor and inquire into violations of women's rights, such as national commissions for women consisting of individuals and experts from outside the Government.

(60) Governments which have not done so are urged to ratify the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child, to ensure full gender equality in all spheres of life. The States parties to these Conventions must comply with their provisions in order to achieve their ultimate objectives, including the eradication of all harmful traditional practices.

(61) NGOs should be active in bringing all available information on systematic and massive violence against women and children, in particular girls, to the attention of all relevant bodies of the United Nations, such as the Centre for Human Rights, the Commission on the Status of Women and specialized agencies, for the necessary intervention. Such information should also be shared with the Governments concerned, women's commissions and human rights organizations.

(62) Women's organizations should mobilize all efforts, including action research, to eradicate prejudicial and internalized values which project a diminished image of women. They should take action towards raising awareness among women about their potential and self-esteem, the lack of which is one of the factors perpetuating discrimination.

B. International action

The Commission on Human Rights and the Sub-Commission on Prevention of Discrimination and Protection of Minorities

(63) The question of traditional practices affecting the health of women and girl children should be retained on the agenda of the Commission on Human Rights and the Sub-Commission, so as to keep it under constant review.

The Commission on the Status of Women

(64) The Commission should give more attention to the question of harmful traditional practices.

(65) All the organs of the United Nations working for the protection and the promotion of human rights, and in particular the mechanisms established by the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, the Covenants on Human Rights and the Convention against Torture, should include in their agenda the question of all harmful traditional practices which jeopardize the health of women and girls and discriminate against them.

(66) Intergovernmental organizations and specialized agencies and bodies of the United Nations system, such as the United Nations Children's Fund, the United Nations Development Programme, the United Nations Population Fund, the United Nations Development Fund for Women, the International Labour Organisation, the United Nations Educational, Scientific and Cultural Organization and the World Health Organization, should integrate in their activities the issue of confronting harmful traditional practices and elaborate programmes to cope with this problem.

United Nations specialized agencies

(67) Close coordination should be established between the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children and the relevant United Nations bodies, special-

ized agencies and regional organizations for the effective implementation of the Plan of Action. All specialized agencies should include in their aid programmes activities relating to the campaign against female genital mutilation and other traditional practices affecting the health of women and girl children.

Non-governmental organizations

(68) National and international non-governmental organizations concerned with protecting the health of women and children should include in their programmes activities relating to traditional practices affecting the health of women and girl children.

(69) International non-governmental organizations concerned with protecting the health of women and children should extend their financial and material support to national non-governmental organizations to ensure the success of their activities.

(70) Non-governmental organizations already positively engaged in activities for the elimination of traditional practices affecting the health of women and children should intensify those activities.

(71) Cooperation should also take place between non-governmental organizations and Governments in developing programmes for the retraining of female genital mutilation practitioners to enable them to achieve financial self-sufficiency through gainful activities.

(72) Non-governmental organizations should continue and reinforce their activities in favour of protecting the human rights of women and girl children, including the promotion of beneficial traditional practices.

Other measures

(73) Health workers should be required to dissociate themselves completely from harmful traditional practices.

(74) All women aware of the problem should be called on to react against traditional practices affecting the health of women and children and to mobilize other women.

(75) Women engaged in combating traditional practices affecting the health of women and children should exchange their experience.

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